

ADVANCE HEALTHCARE DIRECTIVE FORM

This Advance Healthcare Directive form, created as a courtesy by Marc Kress MD & Associates, consists of both a Healthcare Power of Attorney and a Living Will. This document expresses my wishes and instructions for medical care when I am unable to make medical decisions for myself.

My Personal Information

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: (_____) _____

Date of Birth: _____

PART I: HEALTHCARE POWER OF ATTORNEY

Part I allows you to appoint a person to make healthcare decisions for you when you are unable to make healthcare decisions for yourself. If you do not appoint a person in this Part I, the person(s) identified in 20 Pa.C.S.A. §5461(d) are authorized to make healthcare decisions for you.

A. No Healthcare Agent

Initial the box below if you choose not to appoint a person to make healthcare decisions for you when you are unable to make healthcare decisions for yourself. You are not required to appoint a person. If you initial the box below, DO NOT complete Sections B, C, D, and E, below.

_____ I choose not to appoint a healthcare agent.

B. My Healthcare Agent

I designate the person below to be my healthcare agent:

Name: _____

Street Address: _____

City, State & Zip: _____

Telephone: _____ Cell Phone: _____

C. My First Alternate Healthcare Agent

If the person in Section B is unable or unwilling to serve as my healthcare agent, I appoint the following individual as my alternate healthcare agent:

Name: _____

Street Address: _____

City, State, Zip Code: _____

Telephone: _____ Cell Phone: _____

My Second Alternate Healthcare Agent

If my first alternate healthcare agent is unable or unwilling to serve as my healthcare agent, I appoint the following individual as my second alternate healthcare agent:

Name: _____

Street Address: _____

City, State, Zip: _____

Telephone: _____ Cell Phone: _____

D. Authority of My Healthcare Agent

My healthcare agent has the authority to make the following healthcare decisions for me in the event I am unable to make these healthcare decisions for myself. (*You may cross out any healthcare decisions below that you do not want your healthcare agent to make.*)

1. To authorize, withhold, or withdraw medical care and surgical procedures.
 2. To authorize, withhold, or withdraw nutrition (food) or hydration (water) medically supplied by tube through my nose, stomach, intestines, arteries, or veins.
 3. To authorize my admission to, or discharge from, a medical, nursing, residential, or similar facility and to make agreements for my care and health insurance for my care, including hospice and/or palliative care.
 4. To hire and fire medical, social service, and other support personnel responsible for my care.
 5. To take any legal action necessary to do what I have directed.
 6. To request that a physician responsible for my care issue a do-not-resuscitate (DNR) order, including an out-of-hospital DNR order, and sign any required documents and consents.
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E. Additional Authority of My Healthcare Agent

1. If I suffer from severe and irreversible brain damage or brain disease with no realistic hope of significant recovery, I would consider such condition intolerable and the application of aggressive medical care to be burdensome. I therefore request that my healthcare agent respond to any intervening life-threatening conditions in the same manner as directed for an end-stage medical condition or state of permanent unconsciousness as I have indicated in Part II. *(Initial your choice below)*

_____ I Agree _____ I Disagree

2. Below, I list some things which are important to me and provide additional instructions or directions to my healthcare agent:

PART II: LIVING WILL

The following healthcare treatment instructions exercise my right to make my own healthcare decisions. These instructions are intended to provide clear and convincing evidence of my wishes to be followed when I lack the capacity to understand, make, or communicate my treatment instructions and I am permanently unconscious or in an end-stage medical condition.

A. If I have an end-stage medical condition (which will result in my death, despite the introduction or continuation of medical treatment) or am permanently unconscious such as in an irreversible coma or an irreversible vegetative state, and there is no realistic hope of significant recovery, then I choose the following *(initial your choice below)*:

_____ **I DO NOT** want aggressive medical care and give the following instructions:

1. I direct that I be given healthcare treatment to relieve pain or provide comfort even if such treatment may shorten my life, suppress my appetite or breathing, or be habit forming.
2. I direct that all life prolonging procedures be withheld or withdrawn.
3. I do not want any of the following life prolonging procedures: CPR; mechanical ventilation; dialysis; surgery; chemotherapy; radiation treatment; or antibiotics.

_____ **I DO** want aggressive medical treatment and want my healthcare team to attempt to prolong my life as long as possible within the limits of generally accepted medical standards.

B. Additional Information

1. I indicate below whether I want nutrition (food) or hydration (water) medically supplied by a tube through my nose, stomach, intestine, arteries, or veins if I have an end-stage medical condition or I am permanently unconscious and there is no realistic hope of significant recovery (*initial your choice below*):

_____ I do want tube feedings to be given.
_____ I do not want tube feedings to be given.

2. If I designated a healthcare agent in Part I, I indicate below whether my healthcare agent must follow the instructions in this Part II if I am in an end-stage medical condition or am permanently unconscious (*initial your choice below*):

_____ My healthcare agent must follow the instructions in this Part II.
_____ My healthcare agent may use these instructions as guidance and override any instructions I have given in this Part II.

3. I indicate below whether I want to donate my organs and tissues at the time of my death for the purpose of transplant, medical study, or education (*initial your choice below*):

_____ I consent to donate my organs or tissues.
_____ I do not consent to donate my organs or tissues.

PART III: SIGNATURE

Pennsylvania law protects my healthcare agent and healthcare providers from any legal liability for their good faith actions in following my wishes as expressed in this document or in complying with my healthcare agent's direction. On behalf of myself, my executors, and heirs, I further hold my healthcare agent and my healthcare providers harmless and indemnify them against any claim for their good faith actions in recognizing my healthcare agent's authority or in following my treatment instructions.

Having carefully read this document, I have signed it this ____ day of _____, 20__, revoking all previous healthcare powers of attorney and living wills.

(Signature)

Two witnesses at least 18 years of age are required by Pennsylvania law and should witness your signature in each other's presence. A person who signs this document on behalf of and at the direction of the principal may not be a witness. It is preferable if the witnesses are not your heirs, nor your creditors, nor employed by any of your healthcare providers).

(Witness Signature)

(Witness Printed Name)

(Witness Signature)

(Witness Printed Name)